A T T E N T I O N

EMPLOYERS ARE REQUIRED TO PROVIDE THIS FORM TO EACH INJURED WORKER

OMBUDSMAN/CLAIMS ADVISORY
DIVISION OF WORKERS COMPENSATION
KANSAS DEPARTMENT OF LABOR
800 SW JACKSON STREET STE 600
TOPEKA KS 66612-1227

TOLL FREE 1-800-332-0353

If you were hurt on the job and have any questions about Workers Compensation benefits contact the **Ombudsman/Claims Advisory Section** at the Kansas Division of Workers Compensation. The Division of Workers Compensation has full-time personnel who specialize in aiding injured workers with claim information and problems. They can give information about benefits an injured worker may be entitled to receive. They can help try to solve problems with benefits not being paid on time, with medical treatment, with unpaid medical bills, with questions about how to figure settlement amounts, etc. Assistance in Spanish is available at the Division of Workers Compensation.

WHAT TO DO IF AN ACCIDENT OCCURS ON THE JOB:

1. Tell your employer that you were hurt on the job.

2. Follow your employer's instructions on getting medical aid and follow the doctor's instructions.

3. Within 200 days of the date of accident or the date of last payment of compensation for disability or authorized medical care, tell your employer **in writing** that you expect workers compensation benefits for your injury. Your employer might know you were hurt and compensation may be paid, however, you could lose all rights to future compensation if you do not tell the employer **in writing**. This is called a **"Written Claim."** Written claim may be served in person by taking it to the employer and getting a receipt for it or by mailing it to the employer by certified mail, return receipt requested. The post office receipt for the certified letter is generally sufficient proof that you sent written claim.

AVERAGE WEEKLY WAGE: A worker's "average weekly wage" is calculated by adding together the **base wage**, the **average weekly overtime** and the **weekly value of fringe benefits** that have been discontinued.

WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self-insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of

the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3 percent of his average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas compensation law provides for additional benefits.

MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

RESPONSIBILITIES OF THE EMPLOYER:

1. Employers must report all employee injuries to the Division of Workers Compensation within 28 days from the date of injury, or the date the employer learned about the injury, when the employee is wholly or partially incapacitated for more than the remainder of the day, turn, or shift.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits regardless of insurance coverage.

5. Upon receiving notice of an injury, employers must provide the employee with written information to assist the injured worker in understanding their rights and responsibilities in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS:

YOUR CLAIM WILL BE HANDLED BY:

Company _____

Address _____

_____

Contact Person _____

Telephone (_____)_____